STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF OPERATIONS SUPPORT
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, NH 03301
TDD Access: Relay NH 1-800-735-2964
Agency Phone: 603-271-3021

APPLICATION FOR RESIDENTIAL OR HEALTH CARE LICENSE

LICENSE #: _____ EXPIRATION DATE: _____

THIS APPLICATION SHALL BE FILLED OUT IN ACCORDANCE WITH RSA 151:4. A SEPARATE APPLICATION MUST BE SUBMITTED FOR EACH LICENSURE CATEGORY. **PLEASE BE SURE TO COMPLETE THE ENTIRE APPLICATION**. IF A SECTION DOES NOT APPLY TO YOUR FACILITY MARK NOT APPLICABLE (N/A). FAILURE TO COMPLETE THE APPLICATION WILL RESULT IN A DELAY IN THE LICENSURE PROCESS. SEND THE COMPLETED FORM TO THE ADDRESS ABOVE.

Check all applicable items:

License renewal:	☐	New administrator:	☐	*New facility:	☐
**New facility name:	☐	*New owner:	☐	*Change in # of beds:	☐
*Change in classification:	☐	*Change in address:	☐	Other (please explain):	☐

* Requires processing as a new application.
** May require processing as a new application.

LICENSEE: _____TELEPHONE #: (___)_____
NAME OF FACILITY: _____TELEPHONE #: (___)_____
FAX #: (___)_____
STREET ADDRESS:_____CITY:_____STATE:____ZIP:_____
MAILING ADDRESS:_____CITY:_____STATE:____ZIP:_____
ADMINISTRATOR:_____
MEDICAL DIRECTOR (if applicable):_____
FACILITY E-MAIL ADDRESS_____
LABORATORY DIRECTOR (if applicable):_____
DAYS AND HOURS OF OPERATION:_____

IF APPLICABLE:

NUMBER OF PATIENTS SEEN PER DAY:_____
NUMBER OF ESRD STATIONS: Presently licensed _____ To be licensed _____
NUMBER OF BEDS: PRESENTLY LICENSED:_____ TOTAL # TO BE LICENSED:_____
ADDRESS, CITY AND STATE OF ANY BRANCH OFFICE (per He-P 801.08(h)) if applicable:
_____
_____
_____

OWNERSHIP

a. Type of ownership: Association: ☐ Partnership: ☐
Corporation: ☐ Other (explain): ☐
Individual: ☐

b. List name and address of each person having an ownership interest (directly or indirectly) of greater than 5% in the facility.

c. If the licensee is organized as an association or corporation, list the name of the Corporation or association and the name, address and title of each officer.

d. If the licensee is a partnership, list the name(s) and address(es) of all the partners.

. Is this a certified facility? ☐ Yes ☐ No

If you are already a certified facility, is this an increase in services? If yes, please call 1-800-852-3345 ext. 4967

Are you planning on being a certified facility? If yes, please call 1-800-852-3345 ext. 4967

FEES:		
	Facilities with beds	$2.50 per bed per year
	Facilities without inpatient beds	$50.00 per year
	Laboratories	$65.00 per category of testing
	Home Health Care Provider	$20.00 per year

A check or money order (payable to: **STATE OF NEW HAMPSHIRE, TREASURER)**, must be attached to this application.

Applications submitted by those facilities exempt under RSA 151:4 are not required to pay the license fee.

APPLICATION FOR LICENSE RENEWAL SHALL:

1. Be submitted at least 120 days prior to expiration of the current license.

2. Attach qualifications, including education, experience and copies of all applicable licenses for the administrator and medical director (if applicable).

3. Include information relative to whether the facility has been granted any exemptions to the rules by the director of the Department of Health and Human Services and/or the State Fire Marshal.

4. Community Residence must submit the information required by RSA 151:4 III (a)(4).

FACILITY SERVICE DESCRIPTION:

The following information will be used to determine which licensure category your facility shall be placed in.

I. Provide a detailed description of the services and programs you wish to provide.

*II. Describe the facility's health care you wish to provide to residents.

*III. Identify who will provide the health care listed in II.

* To be completed if applying for beds.

SIGNATURES:

This application must be signed by:

1. the owner if a private facility;
2. 2 officers if a corporation;
3. 2 authorized individuals if an association or partnership;
4. the head of the government department if a government unit.

I swear or affirm that the information provided is accurate to the best of my knowledge and belief. The administrator and licensee have never pleaded guilty or been found guilty of abuse, neglect or exploitation by the Division of Elderly and Adult Services, Division of Children and Youth Services or Long Term Care Ombudsman Program, or assault, fraud or a felony against a person in this or any other state. I believe that my facility is in full compliance with RSA 151 and the rules promulgated thereunder. I understand that providing false information shall be grounds for denial, suspension or revocation of a license.

DATE: _____ SIGNED: _____
(NAME AND TITLE)

DATE: _____ SIGNED: _____
(NAME AND TITLE)

CHECK NUMBER: _____ AMOUNT: _____

APPLICATION COMPLETE: _____ NOT COMPLETE: _____

(Describe in comments)

CERTIFICATE OF NEED:	Required	☐	Not Required	☐	Received	☐
LOCAL APPROVAL:	Required	☐	Not Required	☐	Received	☐
LSC INSPECTION:	Required	☐	Not Required	☐	Received	☐
LSC PLAN OF CORRECTION:	Required	☐	Not Required	☐	Received	☐
LICENSURE INSPECTION:	Required	☐	Not Required	☐	Received	☐
PLAN OF CORRECTION:	Required	☐	Not Required	☐	Received	☐
DMH/DS RISK:	Required	☐	Not Required	☐	Received	☐

FEDERAL FACILITY (EXEMPT FROM INSPECTION) YES ☐ NO ☐

LICENSURE CATEGORY:

☐	02	General Hospital	☐	17	Collecting Station
☐	03	Nursing Facility	☐	18	Adult Day Care Provider
☐	04	Residential Care Home Fac	☐	19	Case Management Services
☐	05	Supported Residential Care Fac	☐	21	Equipment Management
☐	06	Outpatient Clinic	☐	22	Homemaker Provider
☐	07	Residential Treatment Rehab Fac	☐	23	Hospice Care Provider
☐	08	Laboratory	☐	24	Hospice - SRCF
☐	09	Home Health Care Provider	☐	25	Special Hospital - Substance Abuse
☐	10	Birthing Center	☐	26	Special Hospital - Psychiatric
☐	11	End Stage Renal Dialysis Ctr	☐	27	Special Hospital - Rehabilitation
☐	12	Ambulatory Surgical Facility	☐	28	Freestanding Hosp Emergency Fac
☐	14	Community Residence	☐	29	Hlth Promo, Disease Prev & Screen
☐	15	ICF/DD	☐	30	Acute Psych Rehabilitation Facility
☐	16	Educational Health Center	☐	31	Neurobehavioral RTRF

REVIEWED BY: _____

(NAME & TITLE) (DATE)

ISSUE ANNUAL LICENSE: YES _____ NO _____

LICENSE CERTIFICATE DATES: FROM _____ TO _____

NUMBER OF PATIENTS/STATIONS/BEDS _____

NOTES:

COMMENTS ON CERTIFICATE:

HOSPITAL AND RESIDENTIAL APPLICATION PROCESS FOR NEW FACILITY, BED INCREASE, CHANGE IN CATEGORY, CHANGE IN ADDRESS

According to RSA 151 :2 (the Residential Care and Health Facilities Law) a facility or agency may not provide any residential or health care services until a valid license is obtained.

Plans must be submitted to Health Facilities Administration and State Fire Marshal's Office for approval prior to commencing work on construction or structural modifications.

1. Obtain application and local approval form.

2. Obtain determination as to whether or not a Certificate of Need is required:

Health Services Planning and Review
6 Hazen Drive
Concord, New Hampshire 03301
(603) 271-4606

The following facilities do not have to obtain this determination:

Residential Care Home	Assisted Living Facility-Supported Residential Care Home
Residential Treatment and Rehabilitation Facility	Accute Psychiatric Rehab., Neuro –RTRF
Hospice House	Laboratory Services
Collecting Station	Home Health Care
Hospice	Birthing Center
End Stage Renal Disease/Dialysis Center	Community Residence
ICF/DD	Educational Health Center
Outpatient Clinic	Health Promotion, Disease Prevention and Screening Clinic
Homemaker	Adult Day Care
Case Management	Tattoo Establishment

UNLESS-you are affiliated with or have an ownership/relationship with any of the following:

Ambulatory Surgical Center
General Hospital
Nursing Facility
Hospice -Supported Residential Care Facility
Special Hospital -Substance Abuse
Special Hospital -Psychiatric
Special Hospital -Rehabilitation
Freestanding Hospital Emergency Facility

3. Complete all sections of the application.

4. Have local health, building, zoning and fire officers sign approval form. (Zoning officer approval is not necessary for Community Residences.) Date of signatures no more than 30 days prior to submission of application.

5. Determine application fee.

6. Submit #2,3,4 and 5 to Health Facilities Administration, 129 Pleasant Street, Concord NH 03301.

7. Submit qualification, including education, experience and copies of applicable licenses with the application for:

a. Administrator.
b. Medical Director (if applicable).

8. If applying for a Home Health Care Provider, Case Management, Equipment Management Organization, Homemaker or Home Health Hospice license, submit:

a. Copy of the authority to do business in New Hampshire from the Secretary of State.
b. Article of Incorporation or Partnership.
c. If applying for a Branch office (see He-P 80 1.08(h), submit the information required by He-P 801.02(d)(5).

9. Within 60 days of receipt of the application you will be notified if your application is complete.

a. If the application is not complete, you will be informed of what is in error .
b. The incomplete application will be returned. When you have corrected the errors or omissions, resubmit the entire application package.

10. Once Health Facilities Administration has received the complete application package two announced inspections will occur .

a. Programmatic inspection to determine compliance with RSA 151, He-P 801 and the other appropriate regulations.
b. Life Safety Code -to determine compliance with State Fire Code and Physical Environment requirements (not required for Home Health, Hospice, Homemaker, Case Management or Equipment Management Organizations.)

11. Within 120 days of receipt of an acceptable application a decision regarding issuance or denial of your license will be made.

12. If you were in full compliance with all inspection requirements, a license and certificate will be issued.

13. If any deficiencies were identified, your licensing request will be denied.

14. If your licensure request is denied, you will have the right to appeal the decision.

15. If you are found to be providing health care services without a license as required by RSA 141:2, a Cease and Desist order will be issued. Legal action including assessing fines may be taken.

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The facility listed below is requesting through the Department of Health and Human Services the following action:

- ☐ Initial Licensing
- ☐ A change in current licensing category
- ☐ Renovation of Existing Building
- ☐ New Construction and/or Addition to Existing Building
- ☐ An increase in current licensed beds / ESRD stations/ or Adult Day Clients

Please note: All applicants must have this form filled out by the local officials, even if they do not see clients at their place of business. This is to confirm that the local authorities are aware that a business is operating at the identified location and that the business complies with all local ordinances.

Local authorities please complete and sign each section.

FACILITY/ESTABLISHMENT NAME: _____
STREET ADDRESS: _____
OWNER'S NAME: _____
ADMINISTRATORS NAME: _____
TELEPHONE NUMBER: _____
PROPOSED TYPE OF FACILITY: _____

HEALTH OFFICER

I HEREBY CERTIFY THAT _____
COMPLIES WITH ALL APPLICABLE HEALTH, SEWAGE AND WATER REGULATIONS FOR THE CITY/TOWN OF _____.

I HEREBY CERTIFY THAT _____ DOES NOT REQUIRE HEALTH, SEWAGE AND WATER APPROVAL OF THIS FACILITY/ESTABLISHMENT.

NUMBER OF BEDS/CLIENTS: _____ NUMBER OF ESRD* STATIONS: _____ N/A: _____

DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF HEALTH OFFICIAL)

BUILDING REGULATIONS

I HEREBY CERTIFY THAT _____
COMPLIES WITH ALL APPLICABLE BUILDING REGULATIONS FOR THE CITY/TOWN OF _____.

I HEREBY CERTIFY THAT _____ DOES NOT HAVE LOCAL BUILDING CODES OR REGULATIONS.

NUMBER OF BEDS/CLIENTS: _____ NUMBER OF ESRD* STATIONS: _____ N/A: _____

DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF BUILDING OFFICIAL)

ZONING REGULATIONS

I HEREBY CERTIFY THAT _____
COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF
_____.

I HEREBY CERTIFY THAT _____ DOES
NOT HAVE LOCAL ZONING REGULATIONS.

NUMBER OF BEDS/CLIENTS: _____ NUMBER OF ESRD* STATIONS: _____ N/A: _____

DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF ZONING OFFICIAL)

FIRE REGULATIONS

THIS CITY/TOWN USES THE FOLLOWING FIRE CODES: (EXAMPLE NFPA 101 (2003 EDITION)
CHAPTER _____.)

_____
_____
_____

☐ I HEREBY CERTIFY THAT _____ FD HAS INSPECTED _____
ON _____ AND OBSERVED THE FOLLOWING VIOLATIONS:

_____
_____
_____

☐ I HEREBY CERTIFY THAT _____ FD HAS INSPECTED _____
ON _____ AND FIND THAT ON THE DATE OF INSPECTION NO VIOLATIONS OF THE FIRE CODE ADAPTED BY THE STATE FIRE MARSHAL AND/OR LOCAL MUNICIPLE CODES WERE OBSERVED.

☐ I HEREBY CERTIFY THAT _____ FD HAS INSPECTED _____
ON _____ AND ALL PREVIOUSLY VIOLATIONS NOTED HAVE BEEN CORRECTED.

NUMBER OF BEDS/CLIENTS: _____ NUMBER OF ESRD* STATIONS: _____ N/A: _____

DATE: _____ SIGNATURE: _____
(FIRE CHIEF OR DESIGNEE)

* ESRD = End Stage Renal Dialysis

COMMENTS: